

DRAFT

QPC(M)14/05

Minutes: 108 - 138

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 16 September 2014 in the
Board Room, J B Russell House
Gartnavel Royal Hospital, 1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)

Dr C Benton MBE	Dr D Lyons
Ms M Brown	Ms R Micklem
Dr H Cameron	Cllr J McIlwee
Mr I Fraser (To Minute 126)	Mr D Sime
Mr K Winter	

O T H E R B O A R D M E M B E R S I N A T T E N D A N C E

Dr J Armstrong	Dr L de Caestecker (To Minute 127)
Mr R Calderwood	Mr R Finnie (To Minute 123)
Professor R Crocket MBE	Mr A O Robertson OBE (To Minute 134)
Rev Dr N Shanks (To Minute 132)	

I N A T T E N D A N C E

Mr G Archibald	..	Interim Lead Director, Acute Services
Ms A Baxendale	..	Head of Health Improvement (From Minute 115 to 133)
Mr J Best	..	Director, Regional Services (For Minute 134)
Mr A Curran	..	Head of Capital Planning and Procurement (From Minute 135)
Mr P Devine	..	Associate Director, Scottish Futures Trust (For Minute 135)
Mr A Gallacher	..	Technical Manager (For Minute 137)
Mr R Garscadden	..	Director of Corporate Affairs
Mr J C Hamilton	..	Head of Board Administration
Mr K Hill	..	Director of Women and Children's Services (For Minute 133)
Mr J Hobson	..	Interim Director of Finance
Ms M A Kane	..	Interim Director, Facilities
Mr M Kingston	..	Audit Scotland
Mr D Leese	..	Director of Renfrewshire CHP (To Minute 133)
Mr D Loudon	..	Project Director - South Glasgow Hospitals Development (From Minute 133)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy
Mr D Ross	..	Director, Currie & Brown UK Limited (For Minute 133)
Mr D Walker	..	Director, Glasgow City CHP (South Sector) (For Minute 127)

108. WELCOME AND APOLOGIES

Mr I Lee, Convener, welcomed Dr D Lyons to his first meeting of the Committee, replacing Mr B Williamson. Apologies for absence were intimated on behalf of Councillor M Cuning, Mr P Daniels and Councillor A Lafferty.

109. DECLARATIONS OF INTEREST

There were no declarations of interest raised.

110. MINUTES OF PREVIOUS MEETING

On the motion of Ms R Micklem and seconded by Councillor J McIlwee, the Minutes of the Quality and Performance Committee Meeting held on 1 July 2014 [QPC(M)14/04] were approved as a correct record.

111. MATTERS ARISING

- (a) Rolling Action List

NOTED

- (b) Assessing the Impact of Proposals to Q&P Committee: Proposed Guidance Template

There was submitted a paper [Paper No 14/90] by the Director of Corporate Planning and Policy which provided guidance on the areas to be covered in the summary paper for patient safety/patient experience, financial implications, staffing implications, equality implications and health inequalities implications. The completion of this summary paper was designed to increase informed decision making and Members' comments were sought prior to its introduction.

Members welcomed the additional guidance and recognised that its success would be judged on the future presentation of papers with an appropriately completed assessment of the impact of the proposals. Ms Micklem asked that the paper also incorporated cross references to the five statements within the Corporate Plan. This was agreed and the new guidance would be amended and issued for implementation with effect from the November meeting of the Quality and Performance Committee. It would however remain a separate paper to the executive summary, which is required to be produced for all Committee papers, noting the key issues covered by the paper.

DECIDED

- That, the proposed guidance, subject to the change notified above, be approved and implemented from the November meeting of the Quality and Performance Committee.

112. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 14/91] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance.

Of the 43 measures which had been assigned a performance status based on their variance from trajectories and/or targets, 25 were assessed as green; 7 as amber (performance within 5% of trajectory) and 11 as red (performance 5% outwith meeting trajectory).

The following HEAT targets/performance indicators had been removed as they had reached their target delivery date:-

- Smoking cessation – one month post-quit;
- Child healthy weight interventions;
- Inequalities cardiovascular health check measure.

Other changes within the report included an update on the 48 hour access to an appropriate GP Practice Team member. This utilised the results of the 2013/14 GP Patient Experience Survey and the results of the 2014 National Better Together Patient Experience Survey.

The key performance status changes since the last report to the Committee included:-

- MRSA/MSSA Bacteraemia cases per 100,000 average occupied bed days, had moved from amber to green;
- Cancer treatment waits – 31 days, had moved from amber to green;
- Admissions to Stroke Unit had moved from amber to green;
- A&E 4 hour maximum wait had moved from red to amber;
- Overtime usage had moved from amber to green;
- Early diagnosis of cancer had moved from green to red;
- Child and Adolescents Mental Health Services waits had moved from green to red;
- Antenatal Care (SIMD) had moved from green to amber;
- Percentage of new outpatient appointment “did not attends” had moved from amber to red;
- Primary Care Nursing Standard – Hand Hygiene Compliance had moved from green to amber.

Exception reports had been provided to Members on the eleven measures which had been assessed as red, and this had included two new measures. The Early Diagnosis of Cancer and Child and Adolescents Mental Health Services waits.

Ms Brown was disappointed at the downturn in performance of Early Diagnosis and Treatment in the First Stage of Cancer and requested that as part of the Annual Screening Programme report to be submitted to the NHS Board in February 2015, the performance against the full stages of cancer care be included in that report. Mr Archibald acknowledged that this had been a disappointing outcome with the NHS Board diagnosing 21.9% of cancers at Stage 1, with the local trajectory being 24.6% in order to achieve the HEAT target of at least 29% by 31 March 2015. Breast cancer had decreased in the number of patients diagnosed at Stage 1 by 5.7% and he referred to the Exceptions Report which set out the performance issues across the range of cancers together with the intended actions to improve performance in these areas. Discussions had been held with clinicians and the staff were engaging with Public Health to see how best to engage with those patients less likely to present with possible symptoms.

Ms Brown and other Members expressed disappointment at the downturn in performance of the Child and Adolescents Mental Health waits after the recent assurances given to the Committee. This was acknowledged, although it did relate to two patients waiting over eight weeks within Inverclyde CHCP and both patients had received their appointments and were no longer on the waiting list.

Ms Brown raised the issue of patients receiving outpatient appointments which were subsequently postponed and a new date given, and this happening 2-3 times, particularly within ophthalmology and rheumatology. Mr Archibald was not aware of the specifics and would speak to Ms Brown separately in order to obtain the details of particular cases. Some clinics did indeed require multiple appointments for patients (glaucoma patients) and cancellations did occur and auditing was taking place to see what the main reasons were for this.

**Interim Lead
Director, Acute
Services**

Ms Micklem welcomed the good news contained in the Patient Survey and asked if the EQIAs of cost savings programmes – A Fair Financial Decisions Report from Acute and Partnerships, which would identify where full EQIAs were required, would be submitted to the Quality and Performance Committee in November. This was confirmed as being the case.

**Director of
Corporate
Planning & Policy**

Mr Winter was concerned at the increase in the number violent and aggressive incidents towards staff and asked what steps were being taken to protect staff when carrying out their duties. Mr Reid indicated that this had been discussed at the Area Partnership Forum and the Staff Governance Committee and additional training was being put in place for staff. He agreed that he would submit a full paper to the Quality and Performance Committee to highlight the areas where such incidents were being reported, and what actions management were taking to mitigate the risks to staff.

**Director of
Human Resources**

NOTED

113. SCOTTISH PATIENT SAFETY PROGRAMME REPORT

There was submitted a paper [Paper No: 14/92] by the Medical Director on the Scottish Patient Safety Programme and in particular, an update on the Hospital Standardised Mortality Ratio (HSMR) and in particular, the position at the Royal Alexandra Hospital/Vale of Leven Hospital.

Scottish HSMR utilised the routine linkage of data obtained from hospital discharge summaries to death registrations from the National Records of Scotland.

It was calculated for all acute inpatient and day case patients admitted to all specialties and took account of patients who died within 30 days from hospital discharge, including deaths which occurred in the community. It was observed deaths against predicted deaths and enabled acute hospitals to monitor their progress in reducing hospital mortality over time. A higher or higher than expected HSMR should be a trigger for further investigation, as in isolation it cannot be taken to imply a poorly performing hospital or poor quality of care.

The rate for NHSGGC hospitals for the period January – March 2014 was 0.83 however the Royal Alexandra Hospital/Vale of Leven Hospital was recorded at 0.99. The NHS Board received an advisory letter from Health Improvement Scotland indicating that the Royal Alexandra Hospital/Vale of Leven Hospital was an outlier when compared with the national mean, and while HSMR should not be viewed as a marker of the quality of the care in any hospital, it was recognised that an unexpected rate/pattern of HSMR should be used as a prompt for exploration of the care provided. A review was now underway involving further data analysis and engagement with the clinical staff and management teams. Dr Armstrong had met with the clinicians to discuss this trend and, in responding to Mr Sime's comment about a previous review undertaken by the former Medical Director, she advised that this had not highlighted anything significant in terms of a trend or any systematic deficiencies in the care provided though had set out where some individual cases could have been managed more effectively but agreed it would be useful to review this previous report as part of this new process.

Dr Armstrong would report further to the Quality and Performance Committee on the progress made in reviewing the position at the Royal Alexandra Hospital/Vale of Leven Hospital together with identifying the steps being taken to try and bring about an improvement in this area.

Medical Director

NOTED

114. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No: 14/93] by the Medical Director providing information on the performance against the national targets for key infection control measures.

For Staphylococcus Aureus Bacteraemia (SAB), the most recent validated results for January – March 2014 demonstrated a SAB rate of 26.3 cases per 100,000 acute occupied bed days, which was below the national average of 28.4 cases. Dr Armstrong provided unvalidated figures which indicated that the monthly SAB rate was still showing a fluctuating trend as yet, particularly within renal.

With regard to the C-Difficile rate for January – March 2014, the NHS Board had a rate of 24.1 cases per 100,000 acute occupied bed days which, again was below the national average of 28.7 cases.

Mr Robertson asked if the ward progress charts for SABs, C-Difficile and hand hygiene compliance rates were still visible within each ward setting. Dr Armstrong indicated that this was indeed the case but she would be pleased to hear from any Non-Executive Member undertaking the SPSP Leadership Walkabouts if they identified any wards where this was not the case.

Dr Benton commended the nursing staff on their consistently high compliance rates

in terms of the hand hygiene rates.

NOTED

115. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS AND FAIs

There was submitted a paper [Paper No: 14/94] by the Medical Director on the handling of adverse clinical incidents together with an update on the current Fatal Accident Inquiries. Dr Armstrong highlighted, in particular, the time sequence of significant clinical incidents reported within the Acute Services Division and the Partnerships per month since April 2008. In addition, Dr Armstrong highlighted the ongoing implementation of the Significant Clinical Incident Policy and, as requested by Members at the previous meeting, a further review of incident reporting levels within the Women's and Children's Directorate.

Dr Armstrong advised that she would report further to the November meeting of the Committee on the three recent maternal deaths. These three deaths all had very different circumstances. She was meeting with the Women's and Children's Directorate in October to discuss each case and would provide a report to the November Q&P Committee meeting.

Medical Director

Ms Brown welcomed the detailed analysis of the rise in significant clinical incidents and investigations within the Women's and Children's Directorate over the last four years. Whilst recognising the high risk nature of obstetric care, she was concerned that the number of investigations had almost doubled over the past four years, year-on-year. Dr Armstrong hoped that the analysis had been helpful together with the focus which the management team within the Women's and Children's Directorate had brought to the issue with their clinical staff. There was a recognition that this was a targeted area of work with a developing safety climate within the Directorate, however, she would pick this up and the reported near-misses in her report to the Quality and Performance Committee in November.

Medical Director

Ms Micklem was concerned at the steady flow of errors made by clinicians i.e. local anaesthetic performed on wrong body part, despite the "stop before you block" process being undertaken and site markings being checked. Dr Armstrong felt that some staff were now too used to the process and did not always use the rigour that the process was designed to ensure. Nursing staff had been further encouraged to challenge clinicians when it seemed they were not following the process as designed. This would be highlighted to the Surgery and Anaesthetics Clinical Governance Group.

In relation to the overall lessons learned from incidents Dr Benton asked whether trainee doctors were given feedback on any errors they had made. Dr Armstrong highlighted the General Medical Council report on their website of collated results and the fact that most significant clinical incidents were the result of a system failure rather than individual failings. The Deanery had commended NHSGGC for its good practice in actioning any concerns/incidents. In addition, as part of the training process, trainees would be given feedback at the time by senior clinicians.

Dr Armstrong highlighted the section of the report on the Fatal Accident Inquiries and made particular reference to the issuing of two recent Determinations. Mr Sime asked in relation to the DH case, as to whether there would be a further report to the Quality and Performance Committee on any corrective action taken in relation to any system defects highlighted by the Determination. Mr Leese advised

that the Determination had been issued on 5 September and had included four additional recommendations to those covered in the initial Investigative Report undertaken by the Child Protection Committee in conjunction with Renfrewshire Council and NHSGGC. He had had a meeting with the Chair of the Child Protection Committee and Chief Executive of Renfrewshire Council in order to discuss the further actions to be taken forward by the Child Protection Committee, in particular the recommendation that mandatory training be given to GPs in the area of child protection. It had been recognised in discussions with the Local Medical Committee and the GP Sub Committee that wider training on protection may be more beneficial. Dr Armstrong would follow up the discussion with Mr Leese in relation to guidance to GPs following a case down south which included additional requirements via the professional route. A further progress report would be submitted to the Quality and Performance Committee.

**Director,
Renfrewshire
CHP**

NOTED

116. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 11 AUGUST 2014

There was submitted a paper [Paper No: 14/95] enclosing the minutes of the Board Clinical Governance Forum meeting held on 11 August 2014.

Mr Lee enquired if the report on the findings and recommendations of the Datix Short Life Working Group, which were due to be submitted to the Quality and Performance Committee in September, would come at a later date. Dr Armstrong advised that once steps had been taken to strengthen the governance structure, a report would indeed be submitted to the Committee in November or January.

Medical Director

NOTED

117. PAGING SYSTEM UPDATE (INCLUDING INFORMATION ABOUT INITIAL INCIDENT)

There was submitted a paper [Paper No: 14/96] by the Interim Lead Director, Acute Services which provided information on the specific incident which had led to the review of the paging system across NHSGGC as well as an explanation as to the rationale on the number of pagers across different hospital sites.

Ms Mary Anne Kane, Interim Director of Facilities, indicated that the incident at Dykebar Hospital in October 2012 had led to a Significant Incident Review being undertaken and no actual delay had occurred in the member of clinical staff being notified of an incident and acting upon that request. The clinician had been in a staff area which was a known blackspot and local processes were in place to augment any difficulties with the paging system should such a problem occur. Since then, the contract had been changed to another supplier in May 2013 and better and wider coverage was now in place.

In relation to the issuing of pager units across different sites, this was driven by demand from operational teams and varied according to the number of emergency teams, service needs and clinical requirements. The volume of pagers now being purchased was reducing as new technologies took their place.

NOTED

118. ADULT WEIGHT MANAGEMENT SERVICES

There was submitted a paper [Paper No: 14/97] by the Director of Public Health which described a new model of weight management services within NHSGGC.

Overweight and obesity was an increasing global public health problem and a significant and increasing challenge within NHSGGC. The associated morbidity had serious health, social and economic consequences for those affected. Unhealthy eating patterns, overweight and obesity contributed to an estimated 12% of NHSGGC's total disease burden with an estimated 268,390 NHSGGC residents (28%) being classified as obese with a body mass index (BMI) of above 30kg/m.

In 2012, the Scottish Government published a four tiered model of service delivery for weight management, essentially making a distinction between the community overweight issues and specialist obesity management. Local arrangements presented a mixed economy of service delivery across the tiers and current levels of service uptake reflected around 0.1% of the current obese population within NHSGGC.

The Director of Public Health led a Short Life Obesity Planning Group to consider the strategic implications and the Corporate Management Team agreed the adoption of a Board-wide weight management framework based on the national tiered model with discrete service strands defined by clinical need, potential for health benefit, readiness to change behaviour as well as BMI. The four tiers were:-

- Tier 1 – Weight management programmes;
- Tier 2 – Community weight management services;
- Tier 3 – Specialist service;
- Tier 4 – Bariatric surgery.

Tier 2 included a tendering process which confirmed Weight Watchers as the successful bidder with a contract to support a minimum of 4000 12 week programmes during 2014-16 for patients whose BMI was >25 with defined levels of clinical need.

Ms Micklem noted that the Corporate Management Team had already approved the adoption of the new model of Weight Management Services and therefore the Quality and Performance Committee were not being asked to approve the introduction of this service. Dr de Caestecker recognised this, and Mr Lee's point, that the paper covered a number of operational issues and was not for decision making. She did highlight however, the issue of priorities for future funding in relation to bariatric surgery.

Rev Dr Shanks enquired as to how people would access this service and Dr Benton asked if the service would be targeted towards deprived areas and our own staff. Dr de Caestecker indicated that referrals to Weight Watchers would be via the patient's own GP or secondary care consultant following an algorithm in order to refer patients to the most appropriate service. In relation to Ms Micklem's comment about whether the service would be accessed equally by females and males, she did acknowledge that targeting men with taking action to reduce obesity remained a real challenge. In relation to targeting the most deprived areas, this had proved difficult and this message would be fed through to GPs. Staff would be able

to access services via their GPs.

Dr Armstrong spoke about the evidence-based effectiveness of bariatric surgery and the fact that it reversed diabetes. NHSGGC, in following national guidelines, would be required to see a rise in cases referred for bariatric surgery from 40 to 108 as a minimum for 2015/16. There would be a timing issue in terms of identifying the additional costs, theatre time and required specialists, and the NHS Board continued to provide gastric banding or sleeve resection in line with the obesity treatment best practice guidance/SIGN guidelines.

NOTED

119. BOWEL SCREENING AND LEARNING DISABILITIES

There was submitted a paper [Paper No: 14/98] by the Director of Public Health at Members' request, providing information on the interventions targeted at supporting participation in bowel screening amongst the NHSGGC population including people with learning disabilities. For the period April 2011 to March 2013, the bowel screening uptake with people with learning disabilities was 27.6% compared to 49.6% overall within NHSGGC.

The paper set out a range of projects which were aimed at closing the equality gap and these were dependent on the active engagement of GPs in the identification of people who required additional support to enable their informed participation in the bowel screening programme.

Dr Benton welcomed this report and enquired about patients with Down's Syndrome. She felt that 50 years of age was too late for screening for this group of patients and it should be set at a lower age. Dr de Caestecker indicated that she would check out the national position in relation to the evidence-based position and advise Dr Benton.

**Director of
Public Health**

Dr Lyons also welcomed the paper and the positive action on the way and enquired about the involvement of the third sector. Dr de Caestecker indicated that the third sector was very much involved and supportive, and there were occasions where they took the lead in specific cases.

NOTED

120. NHS GREATER GLASGOW & CLYDE POLICY ON COMMERCIAL ADVERTISING

There was submitted a paper [Paper No: 14/99] by the Director of Public Health highlighting the role of the NHS Board as a public health organisation in relation to its approved Food Retail Policy. This required all food retailers to avoid commercial advertising associated with high sugar and/or high fat products. The intention was to extend this to create an exemplary environment in which the NHS Board was not associated with products or services which contributed to poor health outcomes for residents. This would be applied to all advertising opportunities within the new South Glasgow University Hospital and Royal Hospital for Sick Children and the paper highlighted unacceptable products associated with poor health and those which would be actively encouraged.

Members welcomed the initiative. Mr Fraser asked why slimming products/protein

body building products were unacceptable and Dr de Caestecker intimated that this was in relation to misleading offers which could lead to debt, rather than the actual products themselves. She would reconsider how this was covered within the policy.

**Director of
Public Health**

In relation to Mr Finnie's question, Dr de Caestecker advised that the section on gambling did not exclude organisations which received lottery funding. She would however, consider further, with the Director of Human Resources, the issue of the NHS Board's own staff lottery. Dr Lyons highlighted that he believed that the issue was more about what damaged people's health rather than what the money was used for.

**Director of
Public Health**

DECIDED

- That, with the amendments suggested, the Policy on Commercial Advertising be approved.

**Director of
Public Health**

**121. NATIONAL PERSON-CENTRED HEALTH AND CARE
COLLABORATIVE: STRATEGIC WORK PLAN AND REPORT**

There was submitted a paper [Paper No: 14/100] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the National Collaborative for Person-Centred Health and Social Care. This was the seventh report highlighting the work undertaken within NHSGGC under the National Person-Centred Health and Care Collaborative and described the progress made locally with the Pilot Improvement Teams in clinical services within the NHS Board's area. The format had been altered in response to the national reporting requirements specified by the Healthcare Improvement Scotland – Person Centred Health and Care Team. A template of requirements had been supplied and this had been built into the main body of the report.

Professor Crocket intimated that there were over 200 patients providing feedback each month and the vast majority had been very positive about the staff and the services they had received. She was aware however, that the report was lengthy and she would welcome Members' comments on any alternative presentation of the report without losing the key messages from individual patients and members of staff.

Ms Micklem welcomed the report although she recognised the need to consider the presentation to Members in future. She particularly liked the Team Staff Experience Reflective Case Study and the steps being attempted to try and improve complaints handling and the recognition of staff intimating that they had not previously discussed complaints widely and now they were having an opportunity to discuss the learning from complaints and how services for patients could be improved in future.

Rev Dr Shanks asked about the section on spiritual and emotional needs and whether Blair Robertson, Head of Spiritual Care, was involved and aware of this process. Professor Crocket advised that she would check what role he has had to date with this element of the report.

Nurse Director

Dr Cameron was delighted to read the very positive comment made about staff and in particular the comment by one patient who stated "They must do some special training, it is like they have all been hand-picked.....They should all get a medal".

Mr Finnie considered it difficult to see what elements of the report could be omitted however, he was keen to see whether future reports could define better the key outcomes and lessons in order that there could be sustainable service improvements for patients. In addition, he would also be keen to see how these improvements would then impact on other programmes/initiatives. Professor Crocket wondered if some of this was already feeding through via the other papers being discussed by the Committee today, in particular the Francis Review and Patient Stories. She would however, consider the point made and what improvements could be made presentationally to future reports particularly in relation to drawing out key points and keeping the depth of the current reporting to members.

Nurse Director

NOTED

122. A PATIENT'S STORY – IAN AND ROSEMARY

There was submitted a paper [Paper No: 14/101] by the Nurse Director providing a reflection on a patient/carer experience and how services could consider involving the patient and carers in decision-making and placing them at the centre of the care pathway.

Professor Crocket took Members through the detail of the Patient Story and asked them to consider how they would wish to use Patient Stories in future at Committee Meetings, Seminars or alternative settings.

In relation to the story, Mr Winter asked if the nurse within the ward phoning the relatives in a proactive way and providing an update on their relatives' condition was to be encouraged. Professor Crocket saw this as good communication in terms of the individual circumstances of this case where the main carer was particularly concerned and anxious about the condition of her husband and had been highly involved in his care. It would be important that each case was considered on its individual merits and that staff knew exactly who they were communicating with in this type of situation.

Members discussed how best to take forward Patient Stories in relation to some NHS Boards doing this at Board Meetings. Some Members preferred the scrutiny role of the Quality and Performance Committee and the opportunity to minute the discussion and this would not be available if presented to an NHS Board Seminar or other type of setting. Members were keen to set the context of their discussions at meetings and felt that a patient-focused way of starting with a Patient Story would be helpful in achieving this. A video of a patient telling their own story was a possibility and Professor Crocket would consider Members' comments with the Corporate Directors and determine how best to take this forward in the future.

Nurse Director

NOTED

123. BRINGING TOGETHER WORK ON QUALITY, CULTURE AND THE FRANCIS REVIEW

(a) FRANCIS REPORT UPDATE

There was submitted a report [Paper No: 14/102] by the Medical Director/Nurse Director which set out the progress to date in implementing the relevant recommendations from the Francis Report into the Mid-Staffordshire NHS Foundation Trust. NHSGGC had set up a Working

Group to review the recommendations and concluded that 92 were relevant to the NHS Board and had considered these under six themes and had identified a series of potential issues and actions for each theme.

The paper and accompanying action plan showed the progress against each action under the six themes. Members were encouraged by the work undertaken in this important area which had afforded the NHS Board the opportunity to systematically review its processes and actions against the findings of the Francis Report.

Generally, the NHS Board had robust arrangements in place with further improvements planned in the most important areas. The challenge remained to ensure that the arrangements were universal and visible at all levels and ensuring that the underlying culture, leadership and clinical engagement promoted provision of the highest quality, safe and patient-centred services. Some of the changes had also been considered under the Chief Executive's Organisational Review.

Dr Cameron believed that the services provided by Allied Health Professionals and Healthcare Scientists had not been adequately covered and the Area Clinical Forum would be interested in discussing this further. Professor Crocket agreed to discuss this further with Dr Cameron at a future Area Clinical Forum.

**Nurse Director/
Chair of
AAHP&HCS**

Ms Brown felt that it was difficult to get into detailed discussion across the many issues covered within the updated progress report and action plan particularly as she was keen to see where the NHS Board started from and what improvement had been made as a result of taking forward the actions relevant to NHSGGC from the Francis Report. It was also important to ensure that the improvements were sustained throughout the organisation. It was agreed that this would be subject to a future NHS Board Seminar.

**Medical
Director/
Nurse Director**

(b) FRANCIS INTO MAINSTREAM

There was submitted a report [Paper No: 14/102] by the Director of Corporate Planning & Policy, Medical Director and Nurse Director setting out how the learning from the Francis Report could be mainstreamed into the Board's existing processes for quality improvement, patient engagement and performance management. The paper briefly outlined the approach in ensuring that the programmes of improvement triggered by the Francis recommendations were progressed in a way which integrated into the NHS Board's wider work. The paper also outlined how changes which are being made as part of the Organisational Review would further strengthen the current arrangements in these identified areas of work.

Members welcomed this overview paper and were keen to discuss how to build on these improvements and how to receive further information on the issues identified as part of the Organisational Review. These would be discussed at the next NHS Board Seminar.

Chief Executive

124. UPDATE ON THE 2013/14 END OF YEAR ORGANISATIONAL PERFORMANCE REVIEWS

There was submitted a paper [Paper No: 14/103] by the Director of Corporate Planning and Policy providing Members with an overview of the cross-system and local key achievements and challenges which emerged from the 2013/14 End of Year Organisational Performance Reviews. Organisational Performance Reviews were carried out twice a year for each part of the system and arranged to ensure a focus on how effectively each part of the organisation was delivering its agreed contribution to the achievement of the corporate priorities set out in the Corporate Plan and in each of the Planning and Policy Frameworks. In addition, they focused on HEAT targets, local key performance indicators and areas of planned activity outlined in Local Development Plans.

The Acute Services Division Senior Management Team and the Partnership Committees received their relevant Organisational Review outcomes for scrutiny and monitoring purposes.

NOTED

125. ANNUAL REVIEW 2013-14: INITIAL FEEDBACK

There was a verbal update by the Board Chair in relation to the Annual Review held on 19 August 2014 in the Marriott Hotel, Glasgow. This was a Non-Ministerial review, however, officials from the Scottish Government Health Directorate were present and would submit to the NHS Board an SGHD outcome letter and action plan for the next 12 months.

The Chair described the meetings held with the Patient Forums, Area Partnership Forum and Area Clinical Forum together with the presentations and the open session at the end when the NHS Board's Senior Management Team answered questions from members of the public. Feedback had suggested that the Annual Review was well received and the idea of having a facilitator to objectively handle questions from members of the public had proven successful. Consideration would be given to the length of presentations and whether it was possible to conduct the public's questions any more inclusively in future.

NOTED

126. INTEGRATED JOINT BOARD DEVELOPMENT

There was submitted a paper [Paper No: 14/104] by the Director of Corporate Planning and Policy asking the Committee to consider an approach to the formation and membership of Integrated Joint Boards (IJBs). Work was underway with the six Local Authorities within NHSGGC's area in order to establish Shadow Integrated Joint Boards and to develop the detailed integration agreements. These would be required to be approved by the respective Councils and the NHS Board by the end of the calendar year, for onward submission to SGHD for consideration and approval. The aim was to establish the formal Joint Integrated Boards from April 2015.

Councillor McIlwee advised that he wished to declare an interest as the current Chair of Inverclyde CHCP and Deputy Leader from the Council, and withdrew

from any further discussions on this matter.

Proposals would need to be finalised on the basis of the final regulations although there was no expectation of any significant change to the current position within the draft regulations. The paper described the current regulations in relation to membership and the position of Chair and Vice Chair of the Integrated Joint Boards. The intention was to ensure a balanced approach across the six Integrated Joint Boards which built confidence for the NHS Board and staff and there was genuine shared leadership across the new partnerships. Members' views were being sought on a possible additional Non-Executive Member for each IJB and the proposal that where the Chief Officer was from a Local Authority background, the Chair would then be drawn from NHSGGC and vice versa.

Ms Renfrew provided specific examples to assist with the clarity of the proposals and members welcomed the approach both in relation to the possible additional membership of the IJBs and the position of the Chair and Vice Chair. It was hoped that this would be helpful in negotiations in bringing together the Integrated Joint Boards across each of the six Local Authority areas. It was also suggested that the Chair rotate between the Local Authority and NHSGGC on a two year basis.

The Board Chair had written to Members at the end of last week setting out for discussion proposals for memberships of standing committees of the Board and the Integrated Joint Boards with effect from 1 April 2015 and these proposals would be further discussed with Members at a suitable forum in the near future.

DECIDED

- That, the proposals set out in the paper be endorsed as the NHS Board's approach to the formation of Integrated Joint Boards.

**Director of
Corporate
Planning &
Policy**

127. DISTRICT NURSING REVIEW

There was submitted a paper [Paper No: 14/105] by the Interim Director of Glasgow City CHP seeking the Committee's agreement to note the progress on the review of District Nursing Services.

Mr D Walker, Director, Glasgow City CHP (South Sector), introduced the paper and took Members through the review of the business case, service specification and responses to comments from consultation. Local and national priorities had provided the basis for a re-examination of the district nursing service and a Programme Board had been formed which oversaw this work and included a range of stakeholders including front line staff, partners from general practice, acute and staff partnership representatives. In taking Members through the paper, Mr Walker highlighted in particular the sections on rebalancing the workforce, the benefits of agile technology, case load and teams, and in particular, in relation to the proposed re-profiling of the workforce, redefining the patient's day, enhancing links with other parts of the health and social care system and the preparation of a learning development plan in relation to the potential future skills shortage.

Mr Walker highlighted that different Partnerships were at different starting points in this process, and following what had been a full and inclusive consultation process, those most affected had been well sighted on the proposals and the main concern related to the planned reductions in the number of Band 6 nurses (offset by an increase in the number of Band 5s).

Ms Micklem felt that more information could have been covered within the Patient Safety/Patient Experience, Equality and Health Inequalities sections of the covering template of the paper. Mr Walker acknowledged this and explained that in relation to patient experience, the proposals were seeking more time with patients against the backdrop of Releasing Time to Care and positive comments that have come out of the Patient Survey. In relation to health inequalities, the proposals followed the resource allocation model to partnerships based on need and this should have been more fully covered within the covering template.

Dr Armstrong indicated that this review was in relation to 550 WTE district nursing staff and one of the major challenges facing the NHS Board in relation to the Clinical Services Review was the need to bring change to better engagement and interface between those nurses in the community and the 17,000 nurses employed within the hospitals. It was important to make the best use of current resources and Ms Renfrew emphasised the need to shift this balance, whilst some of the ongoing problems in the system would continue.

NOTED

128. FINANCIAL MONITORING REPORT FOR THE 4 MONTH PERIOD TO 31 JULY 2014

There was submitted a paper [Paper No: 14/106] by the Interim Director of Finance that set out the NHS Board's financial performance for the four month period to 31 July 2014.

The NHS Board reported an overspend of £1.5m, broken down to £1.1m over budget within Acute Services and £0.4m overspend in Partnerships. It was forecast that a year-end break even outturn would be achieved. In relation to the anticipated figures at the end of August 2014, the overspend was predicted to be £1.4m.

NOTED

129. MEDIA COVERAGE OF NHSGGC JUNE – AUG 2014

There was submitted a paper [Paper No: 14/107] by the Director of Corporate Communications highlighting outcomes of media activity for the period June - Aug 2014. The reported supplemented the weekly media roundup which was provided to NHS Board members every Friday afternoon and summarised media activity including factual coverage, positive coverage and negative coverage.

The paper highlighted the media issues associated with the Commonwealth Games, particularly in relation to the Queen's Baton Relay, the Norovirus outbreak and during this period there was also significant media attention on a perceived threat of ebola being brought into the UK by the Games family members from affected countries.

NOTED

130. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 23 JUNE 2014

There was submitted a paper [Paper No: 14/108] enclosing the minutes of the

Quality Policy Development Group meeting of 23 June 2014.

NOTED

131. STAFF GOVERNANCE COMMITTEE MINUTES OF MEETING HELD ON 5 AUGUST 2014

The minutes of the Staff Governance Committee held on 5 August 2014 [SGC (M)14/03] were submitted to the Committee.

NOTED

132. UPDATED CAPITAL PLAN - 2013/14

There was submitted a paper [Paper No: 14/109] by the Chief Executive highlighting the latest forecast outturn of the Board's Capital Plan following the recent programme reviews which were undertaken as the mid-year point approached. Capital resources for 2014/15 had stood at £179.520m however, since approval of the plan adjustments had been agreed which resulted in a revised capital figure of £181.768m. The increase in available resources related mainly to the incorporation of estimated VAT recovery for Capital Schemes in 2014/15.

Mr Calderwood took members through the detail of the forecast slippage and acceleration together with the intended new allocations of Capital Funds. A further report would be submitted to the Quality and Performance Committee setting out the progress against the planned capital projects.

Chief Executive

NOTED

133. NEW SOUTH GLASGOW HOSPITALS PROGRESS UPDATE – STAGES 2 & 3

(a) NEW ADULT AND CHILDREN'S HOSPITALS

There was submitted a paper [Paper No: 14/110] by the Project Director – New South Glasgow Hospitals Project setting out the progress against Stage 2 (design and development of the new hospitals) and Stage 3 (construction of the adult and children's hospitals). The paper covered three additional items, namely: the background note on the location of the Child Psychiatry Inpatient Unit within the Children's Hospital; a request to approve the recommendations in relation to the site-wide demolitions and Car Park 3 procurement and lastly, a note on the progress and recommendations relating to the Retail Strategy.

As at 15 September 2014, 182 weeks of the 201 week contract had been completed and the project remained within timescale and budget. The contract completion date was now 19 weeks away and remained as 26 January 2015. This would include the handover of the Adult and Children's Hospitals and Car Park 1. Mr Loudon took members through the progress in relation to the construction of both hospitals together with the internal fit out process and the purchase and transfer of equipment. He also highlighted the progress being made in relation to the Teaching and Learning Centre which remained on budget and on time for a completion

date at the end of May 2015. In relation to the new Staff Accommodation, this also remained on budget and on time for completion by April 2015.

Mr Ross took members through the new compensation events which were the upgrade to the main entrance of the Neurological Building; the change to play equipment within the Children's Park; construction of a layby on Govan Road and changes in relation to the operation of the Fastlink/bus stops. All four had no impact on the overall budget. In addition Mr Ross highlighted two potential compensation events; one in relation to a 1 in 10 year weather event in December 2013 and February 2014 and works to the existing entrance upgrade. He explained that a 1 in 10 weather event related to inclement weather patterns which would not normally be seen within a ten year period and this related to particularly wet periods last December and February. Lastly, he identified the compensation events which were being charged to other funding which included the NHS Board's Capital Plan, donations from Yorkhill Children's Charity (specifically in relation to the installation of sky ceilings to specific rooms, changes to data, power, lighting within the main atrium to enable the fitment of distraction therapy equipment, additional power and data as requested by the Science Centre and a change to play equipment within the Children's Park) and funding contained within the budget for Section 75 works.

(b) CHILD PSYCHIATRY INPATIENT UNIT

Mr K Hill, Director of Women and Children's Services, introduced his briefing paper in relation to the location of the Child Psychiatry Inpatient Unit which was a national seven day service for inpatients and day patients up to and around the age of 12 years of age with severe and/or complex mental disorders, emotional and behavioural disorders. Concern had been raised in relation to the Unit being sited on the fourth (top) floor and discussions had been undertaken with clinical staff in relation to integrating the service within the New Children's Hospital. Careful consideration had been given to the security requirements for this patient group and it was also felt to be a quieter area which was beneficial for some patients who were disturbed by an over-stimulating environment. It also enabled the provision of an integrated outdoor space for the children via the roof play area.

Ms Brown remained particularly concerned about the location of this Unit and highlighted the following:-

- Had a full risk assessment been undertaken by clinical and facilities staff?
- Had any expert evidence been taken about its location?
- Had experience of other UK and overseas units been considered?
- Was there any consultation with patients/parents/staff?
- Had the National Services Division been afforded the opportunity to provide comment?

Mr Calderwood explained the process at the detailed design stage of the

plans and the full involvement of clinical staff. If no concerns had been expressed by the clinical staff, it was unlikely that any wider consultation would have been undertaken, however safety would have been a key consideration. Mr Hill would report back to the Quality and Performance Committee with a paper picking up on these points and would arrange for an NHS Board Members Visit to the site, together with relevant clinical staff, to show Members the location of this unit.

**Director of
Women &
Children's
Services**

(c) SITE-WIDE DEMOLITIONS AND CAR PARK 3

As part of the ongoing campus masterplan development, a range of demolitions had been identified which would be required to be undertaken to clear the site of redundant buildings following migration of existing Southern General services into the new hospital facility. This had followed a change in strategy from the use of retained estate as refurbished office space to construction of a new office building. The demolition works had been identified as falling into two distinct areas; the west side of Langlands Drive and to the east side of Langlands Drive.

**NSGH Project
Director**

In addition, the final multi-storey car park also required to be constructed and the paper set out the options available for the procurement of the works associated with the demolitions and presented the different options of pursuing procurement via national frameworks; standalone procurement competition or negotiation and extension of Brookfield Multiplex Construction contract. It was recommended that in relation to the west side of Langlands Drive, the NHS Board enter into dialogue with Brookfield Multiplex Construction to explore the required works, and when appropriate, prepare a paper for endorsement as a compensation event to develop, design and undertake the necessary works.

In relation to the works required to be undertaken on the east side of Langlands Drive (car park and sundry demolitions), plans would be taken forward to develop and implement a standalone procurement competition for the selection of contractors.

Mr Winter intimated that he supported the recommendations contained within the paper.

(d) RETAIL STRATEGY UPDATE

There was provided a paper setting out the selection criteria and details of the scoring under each of the six criteria in relation to the Retail Strategy for the new South Side Hospitals. In addition, following the issuing of a notification of interest to existing occupiers within NHSGGC, expressions of interest to be involved have been submitted.

The intention was now to issue an information pack to those organisations including copies of the NHS Board's Food Retail Policy, selection criteria and offering each the opportunity to formally tender for the provision of their given service at the new South Side Hospitals.

DECIDED

- 1) That, the progress and development of construction of the Adult and Children's Hospitals on the South Side be noted.
- 2) That, the Director of Women and Children's Services submit a further paper to the Quality and Performance Committee – describing the planning process for the Child Psychiatry Inpatient Unit and an NHS Board Members' Visit be arranged to see the facility. **Director of Women & Children's Services**
- 3) That, the NHS Board enter into dialogue with Brookfield Multiplex Construction to explore the required works to complete the west side of Langlands Drive and, when appropriate, submit a compensation event to the Acute Services Strategy Board and Quality and Performance Committee to develop, design and undertake the necessary works. **NSGH Project Director**
- 4) That, the NHS Board develop and implement a standalone procurement competition from a selection of contractors to undertake works on the east side of Langlands Drive to create the car park and undertake sundry demolitions. **NSGH Project Director**
- 5) That, the update on the Retail Strategy be endorsed. **NSGH Project Director**

134. EXPANSION OF AMBULATORY CARE SERVICES AT GARTNAVEL GENERAL HOSPITAL

There was submitted a paper [Paper No: 14/114] by the Director, Regional Services on the progress with the planning of the moves of ambulatory care services from the Western Infirmary to Gartnavel General Hospital and seeking approval to submit the Initial Agreement to the Capital Investment Group meeting on 7 October 2014.

The NHS Board was committed to vacating the Western Infirmary site by December 2016 and a Project Board has been established through the "On the Move" programme to oversee both the expansion of Gartnavel General Hospital and the interim arrangements to ensure the provision of ambulatory care services for the population of west Glasgow. The reprovision of existing ambulatory care services from the Western Infirmary to the Gartnavel General campus should significantly improve patient experience and safety as the existing accommodation had been classified as in need of extensive upgrading and redesign to meet minimum standards for a modern healthcare facility, especially around access and suitability of treatment facilities. The scoping and design fees had been approved as part of the Board's Capital Plan for 2014/15. Gartnavel General Hospital was part of phase III of the Acute Services Review, which was consulted on widely with the public in 2000 and 2002 and approved by Scottish Ministers and the Scottish Parliament in 2002.

Mr Best, Director, Regional Services, took Members through the detail of the Initial Agreement and advised that if the Committee agreed to its submission to the Capital Investment Group, the plan would be to submit an Outline Business Case to Members in February 2015, followed by a Final Business Case in June 2015. This would lead to a start on site in the summer of 2015 with the intention to complete the project by the end of the year. The Initial Agreement contained additional sections introduced by SGHD hence the different format of this document. Mr

Calderwood explained the four phases of the Acute Services Review and the opportunity to move the ambulatory care services from the Western Infirmary to more suitable accommodation. The associated capital funds would be considered along with other schemes and their priority within the NHS Board's 2015/16 Capital Plan.

DECIDED

- That, the progress with planning the move of ambulatory care services from the Western Infirmary to Gartnavel General Hospital be noted together with the timescale for developing the Outline Business Case and Full Business Case and the position in relation to capital in 2014/15 and 2015/16.
- That, the Initial Agreement be approved for submission to the Scottish Government Capital Investment Group meeting to be held on 7 October 2014.

**Director,
Regional
Services**

135. UPDATE ON DISPOSAL STRATEGY

There was submitted a paper [Paper No: 14/111] by the Head of Capital Planning and Procurement setting out the updated projection for the timescale of releasing capital receipts from the disposal of surplus NHS sites.

The NHS Board had 14 former hospital sites which were currently or would shortly be surplus to requirements following the opening of the new South Glasgow University Hospital campus. It was intended to dispose of these sites over the next 3-5 years with the intention of realising significant capital receipts to be invested in healthcare.

It was intended that the sites would be taken to the marketplace in a more informed manner to increase the likelihood of a successful transaction, to reduce the overall timescales and to give greater certainty over net site values and reduce areas of potential conflict with prospective purchasers. This therefore, would include a number of preliminary site investigations, drainage impact assessments, traffic impact assessments and early discussions with Local Authority planning departments about possible changes of use and the possible number of housing units that sites could accommodate.

The disposals programme would be managed by the Capital Planning and Procurement department and the Scottish Futures Trust had agreed to provide support to the NHS Board in their disposal programme and had secured resources of additional staff that would be seconded to the Capital Planning department for the duration of the programme. In attendance at the meeting was Mr Paul Devine from the Scottish Futures Trust.

Mr Curran described the governance structure which would see the Disposal Strategy Group reporting directly to the Property Committee which would, in turn, report to the Quality and Performance Committee.

NOTED

136. INVERCLYDE ADULT & OLDER PEOPLE'S MENTAL HEALTH CONTINUING CARE FACILITY: FULL BUSINESS CASE

There was submitted a paper [Paper No: 14/112] by the Interim Director, Glasgow City CHP providing an update with a refresh of the content of the scheme and an outline of the arrangements required to seek final approval by the SGHD Capital Investment Group.

The Quality and Performance Committee had approved the Outline Business Case at its meeting in January 2014 and this was subsequently approved by the Capital Investment Group at its meeting on 11 March 2014. The development programme sought the Final Business Case (FBC) to be considered by the Capital Investment Group at its meeting on 28 October 2014 and to meet the necessary scrutiny process within SGHD, the FBC required to be submitted by 30 September 2014. The FBC included a more detailed financial analysis of the proposed facilities, which was informed by a Stage 2 submission from Hubco. In order to meet this timescale it would be necessary to seek the Quality and Performance Committee's agreement to a delegated approval arrangement in order to approve the Final Business Case for formal submission to the Capital Investment Group by the end of this month.

Mr Lee asked if it was possible that the current draft of the FBC, recognising the final financial arrangement required to be added at a later date, could be submitted to NHS Board Members at this stage so that they could raise any questions now rather than being asked in a very tight timescale to review, consider and approve the full FBC. Mr Curran agreed that this was entirely feasible and would arrange for the FBC to be submitted to Members shortly.

Thereafter, once the financial profile had been concluded, the finalised FBC would be submitted to Members for consideration. If they were satisfied, the decision to approve the FBC before submission to the Capital Investment Group would be delegated to the Convener.

Members were content with this arrangement.

DECIDED

- That, the progress report on the Inverclyde Adult and Older People's Mental Health Continuing Care Facility be noted.
- That, the draft Final Business Case be submitted to Members for consideration forthwith and the Final Business Case, together with the completed financial profile be submitted to Members for review and consideration. If content, that the Convener be delegated the authority to approve the FBC for submission to the Scottish Government Capital Investment Group for consideration at its meeting on 28 October 2014.

**Head of Capital
Planning**

137. REDUCING CARBON EMISSIONS AND ENERGY CONSUMPTION

There was submitted a paper [Paper No: 14/113] by the Interim Lead Director, Acute Services updating Members on the NHS Board's position from the paper submitted to the Quality and Performance Committee in November 2013 in relation to reducing carbon emissions and energy consumption.

A Carbon Management Plan had been in place since 2009 and this was refreshed and updated in 2012 and 2013 with support from the Carbon Trust and in line with the work being undertaken nationally across NHS Scotland.

Ms Mary Anne Kane, Interim Director of Facilities, advised that, at the end of March 2014, the NHS Board had failed to achieve both the energy and carbon targets associated with the HEAT targets (fossil fuel) with the single biggest impact being the reliance on fossil fuel (oil and gas) and the retained estate still being operational while new estate was functional. The closure of the Victoria Infirmary, Western Infirmary, Royal Hospital for Sick Children and Mansionhouse Unit during the course of 2015 and the migration of these services to the new South Glasgow University Hospital campus will exacerbate the position further although when matched against forecast activity, it has indicated a greater reduction in overall carbon and energy consumption than had been originally estimated.

Ms Kane highlighted the action taken to date in terms of the carbon reduction project, the installation of biomass boilers at four sites, and the move towards developing an Outline Business Case for a Strategic Energy Efficiency Programme (STEEP) for NHS Scotland. Lastly, the NHS Board would also investigate energy supply contracts (ESCO) which are third-party run energy centres in which the NHS Board purchased energy at an agreed cost. Specialised contractors take on the risk and investment profile associated with the delivery. A national framework was in existence and this would be considered going forward.

In relation to STEEP audits, to bring the NHS Board in line with the 2015/16 HEAT and carbon management targets, an indicative investment of circa £72m would be required with a payback of around eleven years. NHS Boards had been encouraged to prioritise their STEEP targets in coming years.

Ms Kane advised that national HEAT targets were currently being reviewed by SGHD and there would be moves towards NHS Boards setting their own local targets to meet their own circumstances. It was her intention to submit another paper to the November meeting of the Quality and Performance Committee setting out the impact of the moves to the new South Glasgow University Hospital campus, the STEEP audits and the possibility of moving to energy supply contracts.

**Interim Director,
Facilities**

The issue of better partnership working with Local Authorities in creating a joint health and care centre had caused challenges for the NHS Board as the joint ventures to date had seen the NHS Board own the site and therefore, be wholly responsible for the carbon footprint of buildings jointly run with Local Authorities. While developing local targets may assist with this, such targets would need to meet SGHD expectations.

Ms Micklem highlighted the need to ensure that the NHS Board did as much as was possible in an important area of work associated with sustainability and reduction in carbon emissions. It was an important responsibility of the NHS Board and every effort should be made to use renewable technology as much as was possible. Ms Kane agreed and would submit a further progress to the next meeting of the Committee.

**Interim Director,
Facilities**

NOTED

138. DATE OF NEXT MEETING

9.00am on Tuesday 18 November 2014 in the Board Room, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1:10pm